Department of Psychiatry, Midland Regional Hospital, Portlaoise

ID Number: AC0030

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, Midland Regional Hospital, Portlaoise
Portlaoise
Co Laois

Approved Centre Type: Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disabilities

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Ms Dervila Eyres, General Manager, CHO8

Inspection Team:
Leon Donovan, Lead Inspector
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Inspection Date: 8 – 11 May 2018
Previous Inspection Date: 30 May – 2 June 2017

Inspection Type: Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: 11 October 2018

2018 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2016 – 2018

Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018

Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2016 – 2018
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1.0 Introduction to the Inspection Process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to “visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate”.

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.
Inspector of Mental Health Services  
Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated Judgement Support Framework, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

In Brief
The Department of Psychiatry (DOP), Midland Regional Hospital, Portlaoise was a 46-bed acute psychiatric unit for the Laois/Offaly area and within Community Healthcare Organisation (CHO) 8. It was located on the ground floor in the Midland Regional Hospital, Portlaoise.

Ten multi-disciplinary teams admitted residents to the unit. Up to ten beds were allocated to the Kildare/West Wicklow area and could be occupied by residents transferred from Lakeview approved centre, which is in the CHO 7 area.

There were four conditions to registration, relating to individual care plans, maintenance, medication and seclusion. Compliance with regulations, rules and codes of practice has remained static since 2016 at approximately 70%. The compliance with three regulations was rated excellent.

Safety in the approved centre
Food safety audits had not been completed periodically and hygiene was maintained to support food safety requirements. Appropriate resident identification processes were in place.

The numbers and skill mix of staff was sufficient to meet resident needs but overtime and agency staff were used to cover leave. Staff were trained in areas such as manual handling, infection control and prevention, resident rights, risk management, incident reporting, and the protection of children and vulnerable adults. Not all health care staff were trained in fire safety, Basic Life Support (BLS), Therapeutic Management of Violence and Aggression (TMVA) and the Mental Health Act 2001. Medication ordering, prescription, storage and administration were all satisfactory.

Appropriate care and treatment of residents
Each resident had a multi-disciplinary individual care plan (ICP), into which the resident had input. Adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes and occupational therapy did not have appropriate facilities. The occupational therapist met with residents, except for those in the high observation unit, on a one to one basis. They held groups outside of the ward as facilities were limited within the ward itself. The approved centre had a recovery centre, which focused on
therapeutic programmes, located off the wards, which residents could attend if they were not placed in the high observation wards. Residents in the high-observation wards were not provided with access to the recovery centre and had no access to therapeutic programmes. There was satisfactory monitoring of residents’ general health on a regular basis. Clinical files were in good order. Two clinical files did not document full initial assessments on admission.

There were four admissions of children since the last inspection in 2017. Provisions were in place to ensure the safety of the child but age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.

Respect for residents’ privacy, dignity and autonomy
There were a number of blanket restrictive practices in operation in the approved centre, which were not based on individual risk assessment. The entrances to both wards were observed to be locked at all times. In high-obs, all residents were subject to blanket restrictions such as the prescription of night clothing during the day. This was demeaning as the risk of absconsion was mitigated by a locked door. There was also no access to mobile phones and there was restricted access to therapeutic and recreational activities. There was no evidence that all residents in high-obs were individually risk assessed as to whether personal phones presented a risk or there was a risk of absconsion. Physical restraint and seclusion were used and the approved centre was found non-compliant in both.

Residents could receive visitors in private and were free to communicate with whom they pleased.

Noticeboards in the nurses’ station on the male ward displayed identifiable resident information, including the full names of residents. A noticeboard located outside the nurses’ station, detailing residents’ full names, was visible to residents from the corridor. CCTV use respected residents’ privacy and dignity. The bathroom and shower facilities for the male seclusion room were located down the corridor. Male residents in seclusion had to cross over from the seclusion room to use the facilities which did not respect their privacy and dignity.

Responsiveness to residents’ needs
The approved centre provided limited access to recreational activities on weekdays and during the weekend and they were not appropriate to the resident group profile. Residents reported there that there were not enough activities taking place in the approved centre. There were not enough resources, activities were dependent upon staff numbers, and they were decided on a day to day basis. There were few opportunities for residents to partake in indoor and outdoor exercise and physical activity.

There was a choice of meals and food was presented in an attractive manner. Information was provided about the approved centre, diagnosis and medication. The complaints procedure was excellent. Ligature points in the approved centre had not been minimised despite the fact that the ligature audit had identified a number of significant ligature risks that required removal. The approved had been painted recently, and some new furniture including recliners had been recently purchased. External areas including the garden required attention at the time of the inspection. Internal areas were in a poor state of repair. It was not clean, hygienic, and free from offensive odours throughout.
Governance of the approved centre

The approved centre was in Community Healthcare Organisation (CHO) 8. The senior management team, incorporating the Quality and Safety Committee, met weekly to review governance issues affecting the Laois/Offaly area, including the approved centre.

There was no risk manager in place at the time of the inspection. The person with responsibility for risk within the approved centre was not known at the time of the inspection. Risk issues from staff were directed towards the assistant director of nursing, but this was an informal arrangement. There was a risk register which was reviewed quarterly and which incorporated clinical risks, corporate risks, and health and safety risks. It was uncertain how risk issues were escalated to the risk register in the absence of a person with responsibility for risk. The risk policy required review.

There was an organisational chart in place which showed the leadership and management structure and the lines of authority and accountability of the approved centre’s staff.

Since 2016, there was a significant improvement in clinical governance.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre was recently redecorated with new furnishings installed.

2. A 0.5 WTE (whole time equivalent) Pharmacy Technician has been employed and provides a stock check and rotation and top-up service.

3. An additional 0.5 WTE perinatal liaison post has been allocated to Midlands Regional Hospital. The nurse received supervision from the clinical director and maintains regular contact with the Clinical Nurse Manager 3 in the approved centre.

4. A streamlined admission pathway for patients from Naas services is now in place. This has resulted in a reduction in duplication of work with admission assessments carried out in Naas being accepted in the approved centre.

5. A new information leaflet for mental health assessment has been created. This leaflet is a guide for persons attending the unit for assessment and outlines who can use the service and what to expect during and after assessment.

6. Dual qualified nursing staff have led training sessions in caring with residents with intellectual disabilities.

7. In order to cover leave and shift rotations, two additional nurses have been trained in Electro-Convulsive Therapy (ECT) with four trained in total now.

8. A Garda liaison group forum was commenced in 2017 to improve communication between the services with quarterly meetings planned.

9. Improved communications between the approved centre and the collocated Emergency Department of Midlands Regional Hospital, Portlaoise with the commencement of an interdepartmental group which led to smoother transitions, improved transfer times and more rapid medical team response times.

10. Improvements to the seclusion pack with the introduction of a checklist to promote compliance with all the requirements of the Rules Governing the Use of Seclusion.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Department of Psychiatry (DOP), Midland Regional Hospital, Portlaoise was the acute psychiatric unit for the Laois/Offaly area and within Community Healthcare Organisation (CHO) 8. Opened in 2004, the approved centre was purpose-built and was situated off the Block Road on the Dublin side of Portlaoise. It was located on the ground floor within the southern section of the Midland Regional Hospital, Portlaoise building.

The approved centre was accessed through the main entrance on the north side of the hospital. There were a number of disabled parking bays close to the entrance of the hospital and there was ample parking for visitors within walking distance with pay stations at a number of convenient locations. The approved centre operated at a maximum capacity of 46 residents and consisted of separate male and female wards. At the time of the inspection there were 24 beds in the male ward and 22 in the female ward. Each ward contained a six-bed high observation area, in which a nurse was present at all times.

A total of ten multi-disciplinary teams admitted residents to the unit. These included six community teams (including one from the Kildare/West Wicklow area), psychiatry of old age, rehabilitation, intellectual disability, and young adult mental health team. Up to ten beds were allocated to the Kildare/West Wicklow area and could be occupied by residents transferred from Lakeview approved centre, which is in the CHO 7 area.

The resident profile on the first day of inspection was as follows:

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>46</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>45</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>10 (incl. 1 on S26 leave)</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>8</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

There were four conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.
**Condition 2:** To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 3:** To ensure adherence to Regulation 23: Ordering Prescribing, Storing and Administration of Medicines, the approved centre shall audit their Medication Prescription and Administration Records (MPARs) on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 4:** To ensure adherence to the Rules Governing the Use of Seclusion, the approved centre shall provide the Mental Health Commission with a report on the rate and duration of episodes of seclusion within the approved centre in a form and frequency prescribed by the Commission.

### 4.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

### 4.4 Governance

The senior management team, incorporating the Quality and Safety Committee, met weekly to review governance issues affecting the Laois/Offaly area, including the approved centre. There were also regular meetings of a local approved centre Governance Committee, which focused on issues pertinent to the approved centre in the light of recent inspection findings. Minutes of recent Drugs and Therapeutic Committee meetings were also provided. The documented proceedings of these various groups confirmed an active governance process was in place within the approved centre.

The Laois/Offaly senior management team meeting took place every month and the minutes from these meetings were provided to the inspection team. This was regularly attended by heads of discipline, senior grade allied health professionals as well as administrative staff. Governance issues affecting the whole service as well as the approved centre were discussed. Topics such as service development, quality and risk, compliance and mental health engagement were discussed at these meetings with outcomes and actions allocated accordingly which evidenced a robust and active agenda at senior management level.

Local approved centre governance meetings took place fortnightly and minutes were provided to the inspection team. This meeting was attended by managers and senior staff members from the approved centre. The minutes of more recent meetings were abridged and did not accurately reflect the actual work being done and range of topics discussed at these meetings. However, there was evidence that many pertinent issues were being discussed including; policies, audits, compliance as well as review of local protocols and procedures.

A drugs and therapeutics meeting took place every six weeks.

Overall, documented minutes of these groups evidenced an active governance process in place for the approved centre.
The inspection team sought to meet with all heads of discipline during the inspection. The inspection team met with the following individuals:

- Executive Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Temporary Principal Psychologist
- Temporary Principal Social Worker

All heads of discipline provided a clear overview of the governance within their respective departments. The executive clinical director attended the approved centre at least once a week. The area director of nursing was on site up to three times per week. The principal social worker came to the approved centre up to twice a month and the principal psychologist and occupational therapy manager attended the approved centre as and when required.

Clear lines of responsibility were evident in each department; heads of discipline attended regular meetings with staff. Clinical supervision was facilitated by all heads of discipline.

All heads of discipline were aware of the issues within their respective disciplines. The clinical director outlined strategic aims in relation to securing a settled staff complement in order to minimise the use of agency staff. Strategic aims were identified by all other heads of discipline. The principal social worker announced that a current key strategic aim, to get one whole time equivalent staff grade social worker assigned to the approved centre, had been achieved. A new social worker was due to begin working there in the coming weeks. Some key operational risks cited by heads of discipline included the lengthy process to get approval for recruitment of staff, difficulty in getting approval for key temporary positions, capacity issues with current staff and staff burn-out due to large workloads.

No formal performance appraisals were in place for all disciplines but staff members’ performance was assessed informally either through the supervision process or at individual meetings with staff members.

### 4.5 Use of restrictive practices

During the inspection the entrances to both wards were observed to be locked at all times with secure entry gained using a key card. If during an admission assessment a resident was deemed to be high risk, then they were placed in one of the high observation (high-obs) areas within the unit. These were six bedded dormitories and there was one of these on each ward. Whilst placed in high-obs all residents were subject to blanket restrictions such as the prescription of night clothing during the day, no access to mobile phones and restricted access to therapeutic and recreational activities area in the common corridor off the wards.

There was no evidence that all residents in high-obs were individually assessed as to whether personal phones presented a risk or there was a risk of absconsion.

Physical restraint and seclusion were used and the approved centre was found non-compliant in both.

### 5.0 Compliance
5.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Activities</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Admission of Children</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.

5.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>

5.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Area Lead from the HSE Mental Health Engagement Office was contacted, but the Area Lead for Mental Health Engagement for this service was on leave at the time of the inspection.

With the residents’ permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents’ experience of the approved centre as outlined below.

During the course of the inspection, nine residents requested to meet with the inspection team and these were all facilitated. The majority of residents were complimentary of the care and treatment in the approved centre however many reported that there was not enough to do during the day. One resident found it difficult to pursue physical activity or exercise during their stay on the unit as there was no exercise programme. While in the high observation area they also reported having very little to do except going for a walk in the internal garden where residents smoked cigarettes.

Residents described the food as “average”, “alright”, “not great” and “could be better” with one resident stating that the vegetables were “overcooked” and another that the ham was “processed”.

Five service user experience questionnaires were completed by residents and returned to the inspection team. All five understood what their individual care plan (ICP) was and four were involved in setting goals for their ICP. Three residents indicated that they knew who their multi-disciplinary team were and all knew who their key worker was. All five residents indicated that they were happy with how staff spoke to them and felt free to communicate with friends, family, and advocates. One questionnaire completed by a resident was highly complimentary of staff and attributed their rapid recovery to the care staff provided.

The Irish Advocacy Network (IAN) representative was interviewed by the inspection team and discussed a number of issues. These included the continued inappropriate placing of residents with intellectual disabilities in the unit as well as the loss of the art room to office space and the weekend activation room not being available at the weekend.
7.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- General Manager/Registered Proprietor Nominee
- Hospital Administrator/Complaints Officer
- Executive Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Temporary Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x 2
- Temporary Principal Psychologist
- Occupational Therapy Manager
- Temporary Principal Social Worker
- Chief Pharmacist

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The service requested clarification on who exactly relevant staff were in relation to the reading of policies as described in the Judgement Support Framework. The inspection team advised the service that the approved centre needed to examine which staff members could be involved in the application of each policy and then should ensure that these staff members had read and understood each policy as required and subsequently documented this.
8.0 Inspection Findings – Regulations

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
# Regulation 4: Identification of Residents

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

## INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the identification of residents, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the identification of residents, as set out in the policy.

**Monitoring:** An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification process.

**Evidence of Implementation:** A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used to ensure that each resident was readily identifiable by staff. The preferred identifiers used for each resident were detailed within residents’ clinical files, and were appropriate to the residents’ communication abilities. The person-specific identifiers were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used to assist staff in distinguishing between residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
Regulation 5: Food and Nutrition

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in July 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policies.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition and this resulted in a three weekly cycle of menu rotation which was introduced.

Evidence of Implementation: The approved centre’s menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs. A variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid was provided to residents. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, and appearance but not in terms of flavour. A number of residents complained about the food when speaking with the inspection team. Hot and cold drinks were offered to residents regularly. Residents had access to safe, fresh drinking water in easily accessible locations in the approved centre, and hot meals were served on a daily basis.

For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. Their special dietary needs were regularly reviewed by a dietitian. An evidence-based nutrition assessment tool was not used. Weight charts were implemented, monitored, and acted upon for residents, where appropriate. Intake and output charts were maintained for residents, where appropriate. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindications with medication.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.

Regulation 6: Food Safety

COMPLIANT

Quality Rating: Satisfactory
(1) The registered proprietor shall ensure:
   (a) the provision of suitable and sufficient catering equipment, crockery and cutlery
   (b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
   (c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:
   (a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
   (b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
   (c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety; which was last reviewed in March 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date HSE training in food safety and hygiene commensurate with their roles.

Monitoring: Food safety audits had not been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, and serving of food. Food was prepared centrally in the main hospital and was transported to the approved centre. Food was prepared in a manner that lessened the risk of contamination, spoilage, and infection.

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Hand-washing areas provided for catering services were appropriate. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, and monitoring pillars.
Regulation 7: Clothing

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident’s individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in May 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy on residents’ clothing. Relevant staff interviewed were able to articulate the processes for residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. While there was an emergency supply of clothing available to residents, the approved centre had an account with a local department store where clothes could be purchased where necessary. A record of residents wearing nightclothes during the day, as indicated by their individual care plan (ICP), was kept and monitored.

Evidence of Implementation: Residents in the high observation unit had night clothing, which they wore at all times, this was in accordance with the approved centre’s policy and the residents’ ICPs. All other residents had an adequate supply of individualised clothing. Residents who were not based in the high observation unit were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 8: Residents’ Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents’ personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident’s individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in December 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. At the time of the inspection there was a safe available for the safekeeping of valuables.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was offered to each resident on admission. It was kept distinct from the resident’s ICP. The checklist was updated on an ongoing basis, and all staff were informed to update it as appropriate.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP and/or in accordance with the approved centre’s policy. The access to and use of resident monies was overseen by two members of staff and the resident or their representative.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 9: Recreational Activities

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in August 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident attendance. This log was recorded in residents’ progress notes. The male ward activities book had details of attendance, which were recorded in a sporadic manner. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided limited access to recreational activities on weekdays and during the weekend. The recreational activities were not, however, appropriate to the resident group profile. Residents felt there that there were not enough activities taking place in the approved centre. The last recorded activity in the female recreational activities book was two months prior to the inspection, and the last recorded before that took place six months previously. The approved centre had a recovery centre, located off the wards, which residents could attend if they were not placed in the high observation wards. The recovery centre focused on therapeutic programmes. Residents in the high-observation wards were not provided with access to the recovery centre.

Information on recreational activities was not provided to residents. The recreational activities taking place on both wards were not appropriately resourced, were dependent upon staff numbers, and were decided on a day to day basis. When activities took place they were organised on the same day and were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities.

Communal areas were suitable for recreational activities, such as sitting rooms. The dining room was cleared to create a space for residents to play table tennis each evening, if they so desired.

Apart from table tennis, there were few opportunities for residents to partake in indoor and outdoor exercise and physical activity. The approved centre did not provide exercise equipment. Records of resident attendance at activities were maintained in group records or in the clinical files.

The approved centre was non-compliant with this regulation because the registered proprietor did not provide access for residents to appropriate recreational activities.
Regulation 10: Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support residents’ religious practices was reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. There were facilities available to support residents’ religious practices, including an on-site oratory, and a church which was located in close proximity to the approved centre. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. Residents had access to multi-faith chaplains. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
### Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to visits. The policy was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

**Monitoring:** Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

**Evidence of Implementation:** There were no visiting restrictions implemented for a resident at the time of the inspection. Appropriate and reasonable visiting times were publicly displayed. Visitors were not permitted to visit residents in the high observation unit, but high observation residents were facilitated to meet visitors in other locations. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly through notices. The visiting room was suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 12: Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in March 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff, specifically medical staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were not monitored on an ongoing basis. Analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and these were documented in the individual care plan. The clinical director or a senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

Not all residents had access to the Internet within the wards. It was the local custom and practice for residents being admitted to the high observation wards to have their mobile devices removed. Those without mobile devices could get supervised access to the Internet and e-mail through a computer terminal located in the corridor outside of the unit. Access to the computer was only provided when staff were available to accompany them. Residents were free to communicate at all times, having due regard to their wellbeing, safety and health.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring, and evidence of implementation pillars.
Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident’s dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

Processes: There was a written policy, which was last reviewed in March 2017 available in relation to the implementation of resident searches by the approved centre. The policy addressed all of the requirements of the Judgement Support Framework, including:

- The management and application of searches of a resident, his or her belongings and the environment in which he or she was accommodated.
- The process for the finding of illicit substances during a search.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy on searches. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. Analysis was not completed to identify opportunities for improvement of the search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical files and search forms for two residents who underwent searches were inspected. Risk had been assessed prior to the search of each resident and their belongings in the search. Resident consent was sought and documented in both cases. General written consent was sought for routine environmental searches.
The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when searches were being conducted.

Searches were implemented with due regard to the residents’ dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Search forms were completed for the clinical files reviewed. Policy requirements were implemented when illicit substances were found as a result of a search.

A written record of every search of a resident, every environmental search, and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 14: Care of the Dying

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

Processes: The approved centre had two separate written operational policies in relation to care of the dying. The Care of the Dying policy was last reviewed in May 2016, and the Management of Sudden Death in the Approved Centre policy was last reviewed in January 2015. The policies included the requirements of the Judgement Support Framework with the exceptions of:

- Advance directives in relation to end of life care, Do Not Attempt Resuscitation (DNAR) orders, and residents’ religious and cultural end of life preferences.
- The process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. No medical staff had signed the log. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

As there had been no deaths in the approved centre since the last inspection, the approved centre was only assessed under the two pillars of processes and training and education for this regulation.

The approved centre was compliant with this regulation.
Regulation 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan: “... a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation.”]

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in November 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents’ ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: All residents had an ICP, ten of which were inspected. All ten inspected were a composite set of documents with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Residents had been assessed at admission by the admitting clinician and an ICP was completed by the admitting clinician to address the immediate needs of the resident, with the exception of two residents who had incomplete initial assessments documented. In one, each page of the assessment had lines drawn through it and in the second, a written note on each page stated ‘see old notes’.

A key worker was identified to ensure continuity in the implementation of each resident’s ICP. All residents received an evidenced-based comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

While ICPs identified the resident’s assessed needs, the ICP template had a tick box for therapeutic activities in the ICP however these were not always documented. The ICPs identified appropriate goals, treatment and care, and the necessary resources for each resident. All ICPs were developed, regularly reviewed, and updated by the residents’ multi-disciplinary team.

Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education, and evidence of implementation pillars.
Regulation 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in August 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: A list of all therapeutic services and programmes provided in the approved centre was available to residents. The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents; however, some assessed needs of residents were not documented in individual care plans.

The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents in the general wards. However, a blanket rule applied to residents in the high observation unit. They were not offered programmes and were not assessed for participation in recovery programmes until they left the high observation unit.

Adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes and occupational therapy did not have appropriate facilities. The occupational therapist met with residents, except for those in the high observation unit, on a one to one basis. They held groups outside of the ward as facilities were limited within the ward itself. Patients in the high observation unit could not go. Residents in the general ward could attend recovery programmes such as the breakfast club, walking club, and soccer group.

While the recovery room was adequate, there was no dedicated room for occupational therapy and psychology. Occupational therapists and psychologists tended to meet with residents on the wards. The occupational therapist also brought residents out swimming.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participant, engagement, and outcomes achieved in...
therapeutic services or programmes within each resident’s clinical file. All the therapeutic programmes and services were provided by staff trained in accordance with their care delivery roles.

The approved centre was non-compliant with this regulation as the residents in the high observation area were not provided with therapeutic services and programmes.
Regulation 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in May 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was examined. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented.

Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident’s care and treatment plan, including needs and risks. There was a record to indicate the resident’s accompaniment requirements on transfer.

The resident was risk assessed prior to the transfer, and documented consent of the resident to their transfer was available. The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, and resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, and monitoring pillars.
Regulation 19: General Health

(1) The registered proprietor shall ensure that:
   (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
   (b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
   (c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies. The policy was last reviewed in March 2017. The policies and procedures included the requirements of the Judgement Support Framework with the exception of the referral process for residents’ general health needs.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes. A new general health physical examination form had been introduced following guidance from the Mental Health Commission.

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, and each of the files inspected evidenced that all residents had received a six-monthly general health assessment.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.

Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre including breast check, cervical screening, retina check (diabetics only), and bowel screening.
The approved centre was a tobacco free campus. Residents were supported to stop smoking through nicotine replacement therapy when required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, and training and education pillars.
Regulation 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in March 2017. The policy addressed all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff, specifically medical staff, had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with a simply-written and user friendly booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details. The information booklet did not detail information on residents’ rights.

Residents were provided with details of their multi-disciplinary team (MDT), in a welcome pack, and individual MDT details were displayed on notice boards in the approved centre. Residents were provided with written and verbal information on their diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. At the time of the inspection there were no restrictions on information regarding a resident’s diagnosis, applied to any resident.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to the residents’ needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required, and these services were organised by the Mental Health Act Administrator.

COMPLIANT
Quality Rating Satisfactory
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring, and evidence of implementation pillars.
Regulation 21: Privacy

The registered proprietor shall ensure that the resident’s privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in March 2017. The policy addressed requirements of the Judgement Support Framework, with the exception of the approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were called by their preferred name. The general demeanour of staff and the way in which staff addressed and interacted with residents was respectful. Staff were discreet when discussing the residents’ condition or treatment needs. Not all residents were wearing clothes that respected their privacy and dignity. Residents in the high observation unit were only permitted to wear night clothing, which did not ensure that their privacy dignity was respected at all times.

All bathrooms, showers, and toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Residents were facilitated to make private phone calls.

Noticeboards in the nurses’ station on the male ward displayed identifiable resident information, including the full names of residents. A second noticeboard located outside the nurses’ station, detailing residents’ full names, was visible to residents from the corridor. Both of these issues were addressed during the inspection.

The bathroom and shower facilities for the male seclusion room were located down the corridor. Male residents in seclusion had to cross over from the seclusion room to use the facilities which did not respect their privacy and dignity.

The approved centre was non-compliant with this regulation for the following reasons:

a) Noticeboards on the male ward, which were visible to residents, displayed the full names of residents.
b) All residents in the high observation area had to wear nightclothes, which did not respect their privacy and dignity.
c) The bathroom and shower facilities for the male seclusion room were located down the corridor and residents in seclusion had to cross over the corridor, which did not respect their privacy and dignity.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in May 2017. The policy addressed two of the seven policy-related requirements of the Judgement Support Framework. The policy did not include:

- The approved centre’s premises maintenance programme, cleaning programme, and utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The identification of hazards and ligature points in the premises.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had not completed a hygiene audit. Ligature audits were completed. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The design of the physical environment of the approved centre provided residents with access to personal space, and appropriately sized communal rooms. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities.

Ligature points had not been minimised. The ligature audit had identified a number of significant ligature risks that required removal, and at the time of the inspection, these had not been addressed.

Suitable furnishings supported resident independence and comfort, but the approved centre was not kept in a good state of repair externally and internally. The unit had been painted throughout and new
curtains had been purchased for both male and female wards since the last inspection. New furniture including recliners had been recently purchased. New bed spreads were also provided to residents.

External areas including the garden required attention at the time of the inspection. The false roofs installed over the windows in the internal garden to prevent absconsion had deteriorated. Internal areas were in a poor state of repair with ceiling insulation in the bathroom falling down, and a rusting shower chair observed. General wear and tear and staining was evident in a number of toilets.

There was an ongoing programme of general and decorative maintenance and records were maintained. A cleaning schedule was implemented, but the approved centre was not clean, hygienic, and free from offensive odours throughout.

While the heating was appropriate and of sufficient temperature, it was controlled centrally through the Building Management System which did not allow residents to control the temperature of their own rooms locally. There was a designated laundry and sluice room, but there was no examination room on the male ward. Remote or isolated areas of the approved centre were monitored.

The approved centre was not compliant with this regulation for the following reasons:

a) Some areas of the premises were not clean or maintained in good structural and decorative condition, 22(1)(a).

b) There were a large number of high risk ligature points evident which had not been mitigated. The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and well-being of residents, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.


### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication; which was last reviewed in July 2017. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Medical staff had not signed the signature log to indicate that they had read and understood the policies. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

**Monitoring:** Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

**Evidence of Implementation:** Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident’s MPAR. A record was kept when medication was refused by the resident.

All entries in the MPAR were legible, and written in black indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident’s care or condition. This was documented in the clinical file. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration and expired medications were not administered. All medicines were administered by a registered nurse or registered medical practitioner and, any advice provided by the resident’s pharmacist regarding the appropriate use of the product was adhered too.

Medication was stored in the appropriate environment, as advised by the pharmacist. The medication trolley remained locked at all times and secured in a locked room. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.
Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 24: Health and Safety

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in March 2017. The policy and safety statement addressed the requirements of the Judgement Support Framework with the following exceptions:

- Infection control measures including; safe handling and disposal of health care risk waste, the management of spillages, raising awareness of residents and their visitors to infection control measures, hand washing, linen handling, covering of cuts and abrasions, response to sharps or needle stick injuries.
- The management and reporting of an infection outbreak, and support provided to staff following exposure to infectious diseases, and specific infection control measures in relation to infection types, e.g. C. diff, MRSA, Norovirus.

Training and Education: Medical staff had not signed the signature log to indicate that they had read and understood the policy policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

Monitoring: The health and safety policy was monitored pursuant to Regulation 29: Operational Policies and Procedures.

Evidence of Implementation: Regulation 24 was only assessed against the approved centre’s written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.
Regulation 25: Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:
   (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
   (b) it shall be clearly labelled and be evident;
   (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
   (d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
   (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2017. The policy addressed the requirements of the Judgement Support Framework, with the following exceptions:

- The maintenance of CCTV cameras by the approved centre.
- The process to cease monitoring a resident using CCTV in certain circumstances.

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the use of CCTV, as set out in the policy.

Monitoring: The CCTV equipment was not checked regularly to ensure it was operating appropriately. This was documented. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. The existence and usage of closed circuit television was disclosed to residents and or his or her representative at all times. The Mental Health Commission had been informed about the approved centre’s use of CCTV.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, and monitoring pillars.
Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy and procedures in relation to its recruitment, selection and vetting of staff. The policy was last reviewed in August 2016. The policy included the requirements of the Judgement Support Framework with the exception of the staff performance and evaluation requirements.

**Training and Education:** Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

**Monitoring:** The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

**Evidence of Implementation:** Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. The numbers and skill mix of staff was sufficient to meet resident needs with overtime and agency staff being used to cover leave. Staff had the appropriate qualifications, skills, knowledge, and experience to do their jobs. There was an organisational chart in place which showed the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

A written staffing plan was not available within the approved centre. All staff training was documented and staff training logs were maintained. Staff were trained in areas such as manual handling, infection control and prevention, resident rights, risk management, incident reporting, and the protection of children and vulnerable adults.

Not all health care staff were trained in the following:

- Fire safety
- Basic Life Support (BLS)
- Therapeutic Management of Violence and Aggression (TMVA)
- The Mental Health Act 2001.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance are available to staff throughout the approved centre. Opportunities were made available to staff by the approved centre for further education and these opportunities were effectively communicated to all relevant staff.

The following is a table of clinical staff assigned to the approved centre.

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<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
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<td>HCA</td>
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<td>CNS</td>
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<td>Occupational Therapist</td>
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<td>Social Worker</td>
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<td>Psychologist</td>
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</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Clinical Nurse Specialist (CNS), Health Care Assistant (HCA)

The approved centre was non-compliant with this regulation because:

a) Not all staff had up-to-date mandatory training in BLS, fire safety and TMAV, 26(4).
b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.


Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation, which refers only to maintenance of records pertaining to these areas.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in July 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The way in which entries in residents’ records were made, corrected, and overwritten.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. There was no documented evidence to indicate that all clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were not included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: A record was initiated for every resident assessed or provided with care and services by the approved centre. Resident records were reflective of the residents’ current status and the care and treatment being provided. Residents’ access to their records was managed in accordance to the Data Protection Acts.

All residents’ records were secure, up to date, in good order, with no loose pages, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were physically stored together, where possible. Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation.

Only authorised staff made entries in residents’ records, or specific sections therein. Hand-written records were legible. Entries were written in black indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved
abbreviations, or meaningless phrases. Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title.

The 24-hour clock was not consistently recorded by medical staff in each entry of residents’ records. Where an error was made on residents’ records, medical entries were not corrected by the processes stipulated in the approved centre’s policy.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Records were retained or destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 28: Register of Residents

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

INSPECTION FINDINGS

The approved centre had a documented electronic register of all residents admitted to the approved centre. The register was available to the Mental Health Commission. It did not include all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006:

- Entries did not record the diagnosis on admission.
- Entries did not record the diagnosis on discharge.

The approved centre was non-compliant with section 2 of this regulation for the following reasons:

a) Entries did not record the diagnosis on admission.
b) Entries did not record the diagnosis on discharge.
Regulation 29: Operating Policies and Procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in March 2017. It included all of the requirements the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. Relevant legislation, evidence-based best practice, and clinical guidelines were integrated into the policies. Operating policies and procedures were appropriately approved, and were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame. The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

Where generic policies were used, the approved centre had a written statement to this effect. Any generic policies used were appropriate to the approved centre and the resident group profile.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
### Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in March 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all relevant staff, specifically medical staff, had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

**Monitoring:** Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals. The Mental Health Administrator kept a record of all tribunals, which identified any issues which were actioned.

**Evidence of Implementation:** The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend their Mental Health Tribunal as required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.
Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident’s individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in place in relation to the management of complaints which was last reviewed in March 2017. The HSE’s Your Service, Your Say complaints policy was also adopted by the approved centre. The policies and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed. Details of the analysis were considered by senior management. Required actions were identified and implemented to ensure continuous improvement of the complaints management process. A new complaints template was developed in response to an analysis of the process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy.

A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged
verbally, in writing, electronically through e-mail, by telephone and through feedback, or suggestion forms.

All complaints were handled promptly, appropriately and sensitively. All complaints regardless of the frequency were investigated fully, with due process applied. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented.

The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented. The complainant’s satisfaction or dissatisfaction with the investigation findings was documented.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in March 2017. The approved centre also had a Patient Safety Statement, which was last reviewed in February 2018. The policy and safety statement addressed requirements of the Judgement Support Framework, with the exception of the following:

- The person with overall responsibility for risk management.
- The responsibilities of the multidisciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- The process for identification, assessment, treatment, reporting, and monitoring of the following risks throughout the approved centre:
  - Organisational risks.
  - Capacity risks relating to the number of residents in the approved centre.
  - Risks to the resident group during the provision of general care and services.
  - Risks to individual residents during the delivery of individualised care.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.
Evidence of Implementation: The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. There was no risk manager in place at the time of the inspection. The person with responsibility for risk within the approved centre was not known at the time of the inspection. Risk issues from staff were directed toward the assistant director of nursing, but this was an informal arrangement. The risk management procedures actively reduced identified risks to the lowest practicable level of risk.

Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at admission, at resident transfer, at resident discharge, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Individual risk assessments were completed in advance of and during resident seclusion, physical restraint, and specialised treatments such as electro-convulsive therapy.

Structural risks, including ligature points remained but there was a plan in place by the approved centre place to address ligatures. Ligatures identified by the approved centre in an audit were mitigated through risk management processes of appropriate resident placement and observation.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 33: Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre had up-to-date insurance. It indicated that coverage was provided under the umbrella of the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.
Regulation 34: Certificate of Registration

COMPLIANT

The registered proprietor shall ensure that the approved centre’s current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

INSPECTION FINDINGS

There was an up-to-date certificate of registration displayed in a prominent position, on the wall of the common area corridor of the approved centre.

The approved centre was compliant with this regulation.
9.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of electro-convulsive therapy (ECT) for involuntary patients. The policy was last reviewed in May 2018. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice and had appropriate training and education in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management.

Although there was no single named consultant anaesthetist with overall responsibility for anaesthesia, consultants on the anaesthetic rota maintained responsibility. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse. The clinical file of one patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient’s capacity to consent to receiving treatment, and this was documented in the patient’s clinical file. The patient was deemed capable of consenting to receiving ECT.

Appropriate information on ECT was given by the consultant psychiatrist to enable the patient to make a decision on whether or not to agree to ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in clear and simple language that the patient could understand. The patient was informed of his or her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia.
A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and/or next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine.

The ECT record which was completed after each treatment was placed in the clinical file, but the signature of the registered medical practitioners administering ECT was not detailed. The ECT register was completed on conclusion of the ECT programme. All pre and post ECT assessments were detailed and recorded in the clinical file. Adverse events during or following ECT were addressed in full and were recorded. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was non-compliant with this rule because the ECT record completed after each treatment, which was placed in the clinical file, was not signed by the registered medical practitioner administering ECT, 11.4 (f).
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) “A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section “patient” includes –
   (a) a child in respect of whom an order under section 25 is in force, and
   (b) a voluntary patient.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of seclusion, dated November 2017. It addressed all of the elements of this rule, including the following:

- Those authorised to carry out seclusion.
- The provision of information to the patient.
- Ways of reducing seclusion rates.

Training and Education: Not all staff involved in the use of seclusion, specifically medical staff, had signed the signature sheet, indicating that they had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: The clinical files of three patients who had been placed in seclusion were inspected. In all cases seclusion was initiated by a registered medical practitioner (RMP) and/or registered nurse. The consultant psychiatrist was notified of the use of seclusion as soon as was practicable, and this was recorded in clinical files. Where seclusion was initiated by a registered nurse, an assessment, including a risk assessment, was completed prior to seclusion taking place. The episodes of seclusion were recorded in the clinical files and seclusion register by the registered medical practitioner. The seclusion register was signed by the responsible consultant psychiatrist within 24 hours.

In each episode, seclusion was used only in rare and exceptional circumstances, as a last resort in the best interests of the patient. It was used after all other interventions to manage patients’ unsafe behaviour had first been considered. Cultural awareness and gender sensitivity were exhibited in each episode of seclusion. In all cases, the implementation and use of CCTV to monitor patients in seclusion was appropriate, and viewing of CCTV was restricted to designated personnel. Patients were informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion, and next of kin were informed in one case. Next of kin were not informed in two cases and the reasons for this were documented in the relevant clinical files.

In each episode of seclusion, a registered nurse directly observed the patients for the first hour. A record of the patients in seclusion was made by the nurse every 15 minutes, and the patient’s level of distress
and behaviour were documented. Nursing reviews and medical reviews in relation to seclusion took place, and were completed within the stipulated timeframe by registered medical practitioners.

Patients in seclusion did not have direct access to adequate toilet or washing facilities. Patients in the male ward accessed a shower in a six bed male dormitory down the corridor. Toilet facilities were positioned across the corridor and patients in seclusion had to cross the corridor to access these. Screening was put in place, but this was not sufficient to ensure patients’ privacy and dignity.

All uses of seclusion were clearly recorded in the clinical files and on the seclusion register. In all episodes of seclusion inspected, patients were informed of the ending of seclusion and the reasons for ending seclusion were recorded in the clinical files. Each episode of seclusion was reviewed by the multi-disciplinary team (MDT), and documented in the clinical file within two working days after the episode of seclusion.

The approved centre was non-compliant with this rule for the following reasons:

a) Not all staff involved in the use of seclusion, specifically medical staff, had signed the signature sheet, indicating that they had read and understood the policy, 10.2, (b).

b) Patients in seclusion did not have adequate toilet or washing facilities, 8.1.
10.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

56. In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where —
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either—
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent—
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either—
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

INSPECTION FINDINGS

The clinical files of four patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was a documented assessment of capacity for all patients.

A Form 17: Treatment without Consent, Administration of Medicine for More than 3 Months – Involuntary Patient (Adult) had been completed for two patients within the required three-month time frame, and copies of same were in the clinical files. Each Form 17 contained the following information:

- The names of the medication prescribed.
- Confirmation of the assessment of the patients’ ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of the discussion with the patients in terms of the nature, purpose, and effects of the medication.
- Any views expressed by the patients.
- Supports provided to the patients in relation to the discussion and their decision-making process.
• Authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
11.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

The Mental Health Act, 2001 (“the Act”) does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.
Use of Physical Restraint

Please refer to the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint, which was last reviewed in January 2018. It addressed the provision of information to residents, details of those who could initiate and implement physical restraint, and the child protection process when a child was physically restrained.

Training and Education: Not all staff involved in physical restraint, specifically medical staff, had signed the signature sheet, indicating that they had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been produced.

Evidence of Implementation: Three clinical files were inspected in relation to the use of physical restraint. In all three cases the use of physical restraint was in exceptional circumstances and as a last resort where each resident posed an immediate risk to themselves, or to others. Each resident was assessed for risk in advance of being physically restrained. Physical restraint was initiated by a registered nurse practitioner or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint.

Each episode was initiated by an appropriate staff member, and a designated staff member was the lead. The episodes of physical restraint were not prolonged beyond the period necessary. Gender sensitivity was demonstrated during each episode.

In all cases it was documented that the consultant psychiatrist was notified about all physical restraint episodes as soon as was practicable. A medical examination was carried out by a registered medical practitioner within three hours of the start of the episode. All residents were informed of the reasons, likely duration, and circumstances leading to the discontinuation of physical restraint. In two cases, next of kin were informed of the use of physical restraint, and in the third case they were not informed but the justification for this was documented in the resident’s clinical file.

Each resident was given the chance to discuss the physical restraint episode with members of their MDT as soon as it was possible to. The use of physical restraint was reviewed by the MDT and documented in the clinical files within two working days.

The approved centre was non-compliant with this code of practice because not all staff involved in physical restraint, specifically medical staff, had signed the signature sheet, indicating that they had read and understood the policy on physical restraint, 9.2(b).
Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in place in relation to the admission of a child, which was last reviewed in September 2016. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training relating to the care of children.

Evidence of Implementation: Three children were admitted to the approved centre since the last inspection. This totalled four admissions, with one child being admitted twice. All children were admitted on a short-term basis with their length of stay ranging from one to two nights. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.

Provisions were in place to ensure the safety of the child, to respond to each child’s special needs as a young person in an adult setting, and to ensure the right of the child to have his or her views heard. Each child was nursed on a one to one basis, in a single room facility within a gender segregated unit. Children had their rights explained, and were provided with information about the ward in a form and language that they could understand. The Mental Health Commission toolkit was given to each child and explained as appropriate to their next of kin.

Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. All staff having contact with each child had undergone Garda vetting. Advice from the Child and Adolescent Mental Health Service was available when necessary. The Youth and Adult Mental Health Service (YAMS), consultant was available and saw each child on the day of their admission. The Mental Health Commission was notified of all children admitted to the approved centre within 72 hours of admission using the associated notification form.

The approved centre was non-compliant with this code of practice because there were four admissions of children under 18 years and age-appropriate facilities and a programme of activities were not provided, 2.5(b).
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. It was last reviewed in May 2018. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

**Training and Education:** All staff involved in delivering ECT were trained in line with best international practice and had appropriate training and education in Basic Life Support techniques.

**Evidence of Implementation:** The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT-suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk voluntary patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had responsibility for ECT management.

Although there was no single named consultant anaesthetist with overall responsibility for anaesthesia, consultants on the anaesthetic rota maintained responsibility. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse. The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed his or her capacity to consent to receiving treatment, and this was documented in their clinical file. The voluntary patient was deemed capable of consenting to receiving ECT.

Appropriate information on ECT was given by the consultant psychiatrist to enable the voluntary patient to make a decision on consent to ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that they could understand. The voluntary patient was informed of his or her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia. The residents’ capacity was assessed by the consultant psychiatrist.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the voluntary patient and/or next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment.
A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine.

The ECT record which was completed after each treatment was placed in the clinical file, but the signature of the registered medical practitioners administering ECT were not detailed. All pre and post ECT assessments were detailed and recorded in the clinical file. Adverse events during or following ECT were addressed in full and were recorded. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was non-compliant with this code of practice because the ECT record completed after each treatment, which was placed in the clinical file, was not signed by the registered medical practitioner administering ECT, 12.4 (f).
Admission, Transfer and Discharge

ON-COMPLIANT
Risk Rating LOW

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission and discharge policies were last reviewed in August 2017, the two transfer policies were last reviewed in May 2017 (The Transfer of Resident Policy) and September 2017, (Patient Transfer to Another Approved Centre). All policies combined included all of the policy-related criteria of the code of practice.

Training and Education: All relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission policy, but not the transfer and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in detail in relation to the admission process. Their admission was on the basis of a mental health illness or mental disorder. The decision to admit was made by the registered medical practitioner (RMP) or Consultant Psychiatrist. The resident was assigned a key-worker. The resident’s family member, carer or advocate were involved in the admission process, with the resident’s consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information; such as work situation, education, dietary requirement. The resident received a full physical examination. All assessments and examinations were documented within the clinical file. During the course of the inspection a number of other clinical files were inspected in relation to other individual regulations. Two of these did not document full initial assessments on admission.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan (ICP). All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the MDT, and the resident’s family. A comprehensive pre-discharge assessment was completed; which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan.

There was appropriate multi-disciplinary team (MDT) input into discharge planning. A preliminary discharge summary was sent to the general practitioner within three days. A comprehensive discharge summary was issued within 14 days. This included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, names and contact details of key people for follow-up, and risk
issues such as signs of relapse. A timely follow up appointment with the resident following discharge was documented, and the follow up appointment took place three days after the resident was discharged.

The approved centre was non-compliant with this code of practice for the following reasons:

a) Audits had not been completed on the implementation of and adherence to the discharge, and transfer policies, 4.19.

b) Admission assessments had not been completed for two residents, 15.1.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 9: Recreational Activities

*Report reference: Page 24*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 1. The registered proprietor did not provide access for residents to appropriate recreational activities. | New
  Corrective Action(s): A system will be put in place to timetable activities and to record activities.
  Post-Holder(s) responsible: Each ward CNM2

  Preventative Action(s): Monitor the recording coupled with a quarterly Audit.
  Post-Holder(s) responsible: CNM3 | Timetable displayed on each Ward | No barriers | 30th September 2018 |
| | | | | |
| | | | | |
### Regulation 16: Therapeutic Services and Programmes

**Report reference:** Page 33 & 34

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 2. The residents in the high observation area were not provided with therapeutic services and programmes. | **Corrective Action(s):**  
An assessment by Recovery programme staff (to include all relevant disciplines) will be undertaken of residents in High Obs. The assessed needs will be documented in the ICP. A needs-based programme of activities will be implemented following this assessment.  
Post-Holder(s) responsible: Recovery staff | Assessment Audit | None | 2 months |
| | **Preventative Action(s):**  
A monitoring programme and Audit the assessment of activities for High Obs Residents will be undertaken.  
Post-Holder(s) responsible: Recovery staff | Assessment Audit | None | 3 monthly initially |
### Regulation 21: Privacy

**Report reference: Page 40 & 41**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Noticeboards on the male ward, which were visible to residents, displayed the full names of residents.</td>
<td>Corrective Action(s): Notice board was removed Post-Holder(s) responsible: CNM2 Male Ward Preventative Action(s): Resolved Post-Holder(s) responsible:</td>
<td>Resolved during MHC Inspection None Achieved</td>
<td>None</td>
<td>Achieved</td>
</tr>
<tr>
<td>4. All residents in the high observation area had to wear nightclothes which did not respect their privacy and dignity.</td>
<td>Corrective Action(s): Risk Assessment Tool &amp; ICP Risk amended as is relevant policy document to reflect the need for Resident Privacy and Dignity. Post-Holder(s) responsible: ADON Preventative Action(s): Monitoring and Audit of completion and implementation of amended assessment tools Post-Holder(s) responsible: MDT</td>
<td>ICP Audit will include assessment of these amended assessment tools None</td>
<td>31st October 2018</td>
<td>Quarterly Audit</td>
</tr>
<tr>
<td>5. The bathroom and shower facilities for the male seclusion room were located down the corridor and residents in seclusion had to cross over the corridor which did not respect their privacy and dignity.</td>
<td>Reoccurring - Monitor as per Condition¹</td>
<td>Monitoring and Audit None</td>
<td>None</td>
<td>Quarterly Audit</td>
</tr>
</tbody>
</table>

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¹ To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
**Regulation 22: Premises**

*Report reference: Page 42*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Some areas of the premises were not clean or maintained in good structural and decorative condition, 22(1)(a).</td>
<td>Reoccurring - Monitor as per Condition²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. There were a large number of high risk ligature points evident which had not been mitigated. The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and well-being of residents, 22(3).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

² To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Regulation 26: Staffing

**Report reference: Page 49**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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</tr>
</thead>
</table>
| **8.** Not all staff had up-to-date mandatory training in BLS, fire safety and TMVA, 26(4). | **Corrective Action(s):**
- All staff will receive training in Fire Safety, Basic Life Support and TMR/MAPA and Mental Health Act training in accordance with best contemporary practice.

Post-Holder(s) responsible: CNMIII and ADON/Compliance Officer. | Staff who are not up to date with training will be prioritised by Line Management. | Trainers planning meeting is scheduled for mid September | Ongoing |

| **9.** Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5). | **Preventative Action(s):**
- Trainers meeting scheduled for Sept to address concerns.

Post-Holder(s) responsible: CNMIII and ADON/Compliance Officer. | Training sessions will be arranged | Trainers planning meeting is scheduled for mid September | Ongoing |
### Regulation 28: Register of Residents

**Report reference: Page 52**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Entries did not record the diagnosis on admission.</td>
<td>Corrective Action(s): Training for NCHD’s on recording diagnosis on Admission &amp; Discharge. NCHD’s to record diagnosis on Admission &amp; Discharge. Post-Holder(s) responsible: ECD</td>
<td>Training event to be provided by ECD</td>
<td>None</td>
<td>31st October 2018</td>
</tr>
<tr>
<td>11. Entries did not record the diagnosis on Discharge.</td>
<td>Preventative Action(s): On going monitoring of Admission &amp; Discharge data. Post-Holder(s) responsible: ECD</td>
<td>Weekly report on any outstanding diagnosis</td>
<td>None</td>
<td>Quarterly measurement</td>
</tr>
</tbody>
</table>
### Rules: Section 59 – The Use of Electro-Convulsive Therapy

**Report reference: Page 62**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. The ECT recorded completed after each treatment, which was place in the clinical file, was not signed by the registered medical practitioner administering ECT, 11.4 (f).</td>
<td>Corrective Action(s): Education regarding the need to ensure all healthcare records are completed in full by the Registered Medical Practitioner. Post-Holder(s) responsible: ECT Tutor. Preventative Action(s): Monitoring of all ECT documentation Post-Holder(s) responsible: ECD</td>
<td>Induction programme monitoring.</td>
<td>None</td>
<td>One month</td>
</tr>
<tr>
<td>New</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Rules: Section 69: The Use of Seclusion

*Report reference: Page 64 & 65*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Not all staff involved in the use of seclusion, specifically medical staff, had signed the signature sheet, indication that they had read and understood the policy, 10.2 (b).</td>
<td>Corrective Action(s): A teaching session for medical staff&lt;br&gt;Post-Holder(s) responsible: ECD&lt;br&gt;Preventative Action(s): Annual examination of policies signatures&lt;br&gt;Post-Holder(s) responsible: ECD</td>
<td>Weekly Consultants meeting &amp; NCHD weekly teaching sessions&lt;br&gt;Monitoring and Auditing of policy signature bank.</td>
<td>None&lt;br&gt;None</td>
<td>2 Months&lt;br&gt;31st October 2018</td>
</tr>
<tr>
<td>14. Patients in seclusion did not have adequate toilet or washing facilities, 8.1.</td>
<td>Monitor as per condition³</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

³ To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
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</tr>
</thead>
</table>
| 15. Not all staff involved in physical restraint, specifically medical staff, had signed the signature sheet, indication they they had read and understood the policy on physical restraint, 9.2 (b). | Corrective Action(s): A teaching session for Medical staff  
Post-Holder(s) responsible: ECD  
Preventative Action(s): Annual examination of policies signatures  
Post-Holder(s) responsible: ECD | Weekly Consultants meeting & NCHD weekly teaching sessions | None | 2 months  
None | 31st October 2018 |
## 16. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5 (b).

<table>
<thead>
<tr>
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</thead>
</table>
| Reoccuring                | Corrective action(s):  
A programme of age appropriate educational activities in so far as practicable, have been devised with the assistance of the specialised adolescent unit. (Supporting documentation is attached – Ref 1)  
We will continue to strive to source age appropriate facilities for admission, as soon as possible.  
Post-Holder(s) responsible: ECD  
Preventative action(s): On-going Audit of child admissions to the Approved centre, will be undertaken six monthly.  
Post-holder(s): ECD | Completed | National shortage of age appropriate beds. | Ongoing |

Post-Holder(s): ECD
### Codes: Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

**Report reference: Page 72**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. The ECT record completed after each treatment, which was placed in the clinical file, was not signed by the registered medical practitioner administering ECT, 12.4 (f).</td>
<td>Corrective Action(s): Education regarding the need to ensure all healthcare records are completed in full by the Registered Medical Practitioner. Post-Holder(s) responsible: ECT Tutor. Preventative Action(s): Monitoring of all ECT documentation Post-Holder(s) responsible: ECD</td>
<td>Induction programme monitoring.</td>
<td>None</td>
<td>One month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31\textsuperscript{st} December 2018</td>
</tr>
</tbody>
</table>
### Codes: Admission, Transfer and Discharge

**Report reference: Pages 74 & 75**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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</tr>
</thead>
<tbody>
<tr>
<td>18. Audits had not been completed on the implementation of and adherence to the discharge, and transfer policies, 4.19.</td>
<td>Corrective Action(s): Audit tool has been developed. Undertake audit of same 6 monthly. Post-Holder(s) responsible: Clinical Tutor</td>
<td>6 monthly Audit</td>
<td>None</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; October 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Evaluation of 6 monthly audit results. Post-Holder(s) responsible: Clinical Tutor</td>
<td>6 monthly Audit results evaluation</td>
<td>None</td>
<td>6 Monthly</td>
</tr>
<tr>
<td>19. Admission assessments had not been completed for two residents, 15.1.</td>
<td>Corrective Action(s): Educational session with NCHD's Post-Holder(s) responsible: ECD</td>
<td>Audit</td>
<td>None</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; October 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Monitoring via Audit Post-Holder(s) responsible: ECD</td>
<td>Audit</td>
<td>None</td>
<td>6 Monthly</td>
</tr>
</tbody>
</table>